

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-039998

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 5566

STATE FILE NUMBER

| | | |
|---------------------|--------------|--|
| VS 300 Rev. 4/59 | DATE AMENDED | AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF |
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| 2 8:50 | | |
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| 4 1 | | |
| 5 2 | | |
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| 7 1 | | |
| 8 1 | | |
| 9 331X | | |
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| 12 68-0 | | |
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|---|---|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY JACKSON | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE KANSAS b. COUNTY LEAVENWORTH | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) KANSAS CITY | | c. CITY OR TOWN LEAVENWORTH | |
| Length of stay in 1b 1 month | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION TRINITY LUTHERAN HOSPITAL | | d. STREET ADDRESS (If outside, give location) 807 SOUTH 7th STREET | |
| 3. NAME OF DECEASED (Type or print) First GRETCHEN T Middle LANGE Last LANGE | | 4. DATE OF DEATH Month OCTOBER 11, 1963 Day 11 Year 1963 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 9-18-1887 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (City and state or country) Leavenworth, Kans. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME Crist Wuest | | 13b. MOTHER'S MAIDEN NAME Mary Weitznets | |
| 14. NAME OF HUSBAND OR WIFE Robert August Lange, Sr. | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. 331X | | 17. INFORMANT ROSE KRONNE Address 800 Cherokee Leavenworth, Kans. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Acute DUE TO (b) Hypostatic Congestion DUE TO (c) Cerebral Hemorrhage PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of Item 18.) | |
| 20c. TIME OF INJURY Hour 9:00 P. Month, Day, Year 10-7-63 | | 20d. CITY, TOWN, OR LOCATION LEAVENWORTH KANSAS | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. COUNTY | |
| 20g. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20h. STATE | |
| 21. I attended the deceased from 10-7-63 to 10-11-63 and last saw her/him alive on 10-11-63 Death occurred at 9:00 P. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE Otto W. Theel M.D. | | 22b. ADDRESS 4301 Main St. KCMo | |
| 22c. DATE SIGNED 10-12-63 | | 22d. LOCATION (City, town, or county) (State) LEAVENWORTH KANSAS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | | 23b. DATE OCT. 12, 1963 | |
| 23c. NAME OF CEMETERY OR CREMATORY 1331 BROWN BLVD. KANSAS CITY, MISSOURI | | 23d. LOCATION (City, town, or county) (State) LEAVENWORTH KANSAS | |
| 24. FUNERAL DIRECTOR D. W. HARRISON'S SONS - KANSAS CITY, MISSOURI | | 25. DATE RECD. BY LOCAL REG. 10-14-63 | |
| 26. REGISTRAR'S SIGNATURE Beasie Smith | | 27. (Licensed Embalmer's Statement on Reverse Side) | |

USE BLACK INK
OR
TYPEWRITER RIBBON

810000-14-3

10. Oct. 19. 1919
4901 1919
x

NOV 1 1919

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Vern Lawler

Licensed Embalmer No. 4915

P. O. Address K6 7th

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.